UnitedHealthcare®

Summary of Benefits and Coverage: What This Plan Covers & What it Costs

Coverage Period: 01/01/2013 - 12/31/2013
Coverage for: Employee + Family | **Plan Type:** EP1

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.myuhc.com or by calling 1-877-844-4999

Important Questions	Answers	Why This Matters
What is the overall deductible?	Network: **$1,000** Individual **$2,000** Family Per Calendar Year Does not apply to copays, pharmacy drugs, and services listed below as "No Charge."	You must pay all the costs up to the deductible amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the deductible starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the deductible.
Are there other deductibles for specific services?	No, there are no other deductibles.	You don't have to meet deductibles for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out-of-pocket limit on my expenses?	Network: **$5,000** Individual **$10,000** Family	The out-of-pocket limit is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services, including the overall deductible. This limit helps you plan for health care expenses.
What is not included in the out-of-pocket limit?	Premium, balance-billed charges, health care this plan doesn't cover, prescription drugs and copays.	Even though you pay these expenses, they don't count toward the out–of–pocket limit.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for specific covered services, such as office visits.
Does this plan use a network of providers?	Yes, this plan uses network providers. If you use a non-network provider you will be responsible for 100% of the charges. For a list of network providers, visit www.myuhc.com or call 1-877-844-4999	If you use a network doctor or other health care provider, this plan will pay some or all of the costs of covered services. Be aware, your network doctor or hospital may use a non-network provider for some services. Plans use the term network, preferred, or participating for providers in their network. See the chart starting on page 2 for how this plan pays different kinds of providers.
Do I need a referral to see a specialist?	No. You don't need a referral to see a specialist.	You can see the specialist you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 6. See your policy or plan document for additional information about excluded services.

- Co-payments (copays) are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- Co-insurance (co-ins) is your share of the costs of a covered service, calculated as a percent of the allowed amount for the service. For example, if the plan's allowed amount for an overnight hospital stay is $1,000, your co-insurance payment of 20% would be $200. This may change if you haven't met your deductible.
- The amount the plan pays for covered services is based on the allowed amount. If a Non-Network Provider charges more than the allowed amount, you may have to pay the difference. For example, if a Non-Network Provider hospital charges $1,500 for an overnight stay and the allowed amount is $1,000, you may have to pay the $500 difference. (This is called balance billing.)
- This plan only covers services if rendered by network providers. Exceptions include emergency services as described in your policy

Common Medical Event	Services You May Need	Your cost if you use a Network Provider	Your cost if you use a Non-Network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	20% co-ins	Not Covered	None
	Specialist visit	20% co-ins	Not Covered	None
	Other practitioner office visit	20% co-ins per visit for Manipulative (Chiropractic) Services.	Not Covered	Benefits are limited to 20 visits per policy year.
	Preventive care / screening / immunization	No Charge	Not Covered	Includes preventive health services specified in the health care reform law.
If you have a test	Diagnostic test (x-ray, blood work)	20% co-ins	Not Covered	None
	Imaging (CT/PET scans, MRIs)	20% co-ins	Not Covered	None
If you need drugs to treat your illness or condition. More information about prescription drug coverage is available at www.myuhc.com..	Tier 1 - Your Lowest-Cost Option	Retail: 15% co-ins Mail-Order: 15% co-ins	Not Covered	Provider means pharmacy for purposes of this section.Retail: Up to a 31 day supply.Mail-Order: Up to a 90 day supply. You may need to obtain certain drugs, including certain specialty drugs, from a pharmacy designated by us.
	Tier 2 - Your Mid-Range Cost Option	Retail: 25% co-ins Mail-Order: 25% co-ins	Not Covered	
	Tier 3 - Your Highest-Cost Option	Retail: 40% co-ins Mail-Order: 40% co-ins	Not Covered	$2,000 Out-of-Pocket Maximum per policy period
	Tier 4 - Additional High-Cost Options (Specialty)	Retail: 50% co-ins Mail-Order: 50% co-ins	Not Covered	You may be required to use a lower-cost drug(s) prior to benefits under your policy being available for certain prescribed drugs.

Common Medical Event	Services You May Need	Your cost if you use a Network Provider	Your cost if you use a Non-Network Provider	Limitations & Exceptions
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% co-ins	Not Covered	None
	Physician/surgeon fees	20% co-ins	Not Covered	None
If you need immediate medical attention	Emergency room services	20% co-ins	20% co-ins	None
	Emergency medical transportation	20% co-ins	20% co-ins	None
	Urgent care	20% co-ins	Not Covered	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% co-ins	Not Covered	None
	Physician/surgeon fees	20% co-ins	Not Covered	None
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	20% co-ins	Not Covered	None
	Mental/Behavioral health inpatient services	20% co-ins	Not Covered	None
	Substance use disorder outpatient services	20% co-ins	Not Covered	None
	Substance use disorder inpatient services	20% co-ins	Not Covered	None
If you become pregnant	Prenatal and postnatal care	20% co-ins	Not Covered	Routine pre-natal care is covered at No Charge.
	Delivery and all inpatient services	20% co-ins	Not Covered	
If you have a recovery or other special health need	Home health care	20% co-ins	Not Covered	Benefits are limited to 60 visits for skilled care services per calendar year.
	Rehabilitation services	20% co-ins	Not Covered	Depending upon the type of therapy, there is a limit of 60 visits per policy period
	Habilitation services	Not Covered	Not Covered	None

Common Medical Event	Services You May Need	Your cost if you use a Network Provider	Your cost if you use a Non-Network Provider	Limitations & Exceptions
	Skilled nursing care	20% co-ins	Not Covered Not Covered	Limited to 60 days and Non-Network Benefits limited to days per policy period Pre-Authorization required for Prior Notification is required for certain services. Failure to obtain prior notification may result in a reduced benefit.
	Durable medical equipment	20% co-ins	Not Covered	Limited to $5000 maximum per policy period if the device is determined to be non-essential. Covers per policy period 1 per type of DME (including repair/replacement) every 3 years. Hearing Aids are limited to one every 3 years and a separate $5,000 per calendar year maximum.
	Hospice service	20% co-ins	Not Covered	None
If your child needs dental or eye care	Eye exam	20% co-ins	Not Covered	Limited to 1 exam every 1 years
	Glasses	Not Covered	Not Covered	No coverage for Glasses
	Dental check-up	Not Covered	Not Covered	No coverage for dental check-up.

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)		
• Acupuncture	• Glasses	• Non-emergency care when traveling outside the U.S.
	• Habilitation Services	• Private-duty nursing

• Cosmetic surgery • Dental care (adult/child)	• Infertility treatment • Long-term care	• Routine foot care • Weight loss programs

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)		
• Hearing aids may be covered with limitations	• Routine eye care (adult) may be covered with limitations	• Bariatric surgery limited to one surgery per lifetime

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a premium, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-866-747-1019. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or visit www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or visit www.cciio.cms.gov.

Your Grievance and Appeals Rights :

f you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to appeal or file a grievance. For questions about your rights, this notice, or assistance, you can contact the Member Service number listed on the back of your ID card or visit www.myuhc.com. Additionally, a consumer assistance program may help you file your appeal. A list of states with Consumer Assistance Programs is available at www.dol.gov/ebsa/healthreform and http:///ciio.cms.gov/prgrams/consumer/capgrants/index.html.

Para obtener asistencia en español, llame al número de teléfono en su tarjeta de identificación
若需要中文协助，请拨打您会员卡上的电话号码。
Dine k'ehji shich'i' hadoodzih ninizingo, bee neehozin biniiye nanitinigii number bikaa'igii bich'i' hodiilnih
Para sa tulong sa Tagalog, tawagan ang numero sa iyong ID card.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost also will be different.

See the next page for important information about these examples.

Having a baby

(normal delivery)

- **Amount owed to providers:** $7540
- **Plan Pays** $5240
- **Patient Pays** $2300

Sample care costs:

Hospital charges (mother)	$2700
Routine obstetric care	$2100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7540**
Patient pays:	
Deductibles	$1000
Co-pays	$0
Co-insurance	$1100
Limits or exclusions	$200
Total	**$2300**

Managing type 2 diabetes

(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5400
- **Plan Pays** $3720
- **Patient Pays** $1680

Sample care costs:

Prescriptions	$2900
Medical Equipment and Supplies	$1300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5400**
Patient pays:	
Deductibles	$1000
Co-pays	$0
Co-insurance	$600
Limits or exclusions	$80
Total	**$1680**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied to the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.
- If other than individual coverage, the Patient Pays amount may be more.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **co-payments**, and **co-insurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No**. Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes**. When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes**. An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **co-payments**, **deductibles** and **co-insurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.